AREA/ DESCRIPTION	TASKS
MEMBER SERVICES	
Interpreter Services	
Oral interpreter services must be provided free of charge to non-English speaking enrollees who request assistance. [438.10(c)(4)]	Arrange for vendor to provide services as needed
Provider Directory	
A directory must be compiled and maintained. The directory must list the name, location and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. The directory must also identify any languages other than English spoken by the provider and must include an indicator to identify those who are accepting new patients. [438.10(e)(2)(ii)(D)]	Develop directory
	Survey providers on language capacity and open panel issues
	Print a supply for distribution on request
	Post on website
	Develop process for periodic updates
Notification of Terminating Providers	
OVHA must notify an enrollee whose PCP terminates their participation in Medicaid within 15 days of the provider's notice to the state. Enrollees who are regularly seeing a provider who is not their PCP must also be similarly noticed. [438.10(f)(5)]	Develop process for identification of terminating providers
	Draft notice to enrollees
	Identify process for determining which enrollees have been "regularly treated" by any terminating provider
	Print and mail notices within 15 days to affected enrollees
Enrollee Handbook	
Develop and maintain a current enrollee handbook which covers how to access care, enrollee rights and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal. Handbooks must be distributed to new enrollees within 45 days of enrollment. Handbooks must be available in languages other than English if five (5) percent or more of Demonstration enrollees speak that language. [438.10]	Assess need for languages other than English (documentation for CMS)
	Draft handbook
	Disseminate for input, finalize based on comments received
	Print a supply for initial distribution
	Develop and execute handbook distribution process on an ongoing basis
	Post handbook on website

AREA/ DESCRIPTION	TASKS
Advance Directives	
OVHA must prepare and make available information on Advance Directives. [438.6(h)(2)(i)]	Develop materials
	Print a supply for distribution upon request
	Post information on website
	Draft informational notice on Advance Directives and distribute for posting in physicians' offices
Member Helpline	
OVHA must maintain a toll-free member hotline during normal business hours to answer enrollee inquiries and to accept verbal grievances or appeals. [438.406(a)(1)]	
GRIEVANCES & APPEALS	
Notice of Adverse Action	
OVHA must provide a written Notice of Adverse Action to each enrollee and their requesting provider of any decision to deny a services authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice must be sent within 14 days of the receipt of the request for services, unless that timeframe might, in the opinion of the requesting provider, seriously jeopardize the enrollee's health. In the latter event, the notice must be sent within three (3) business days of the request. [438.210(c)]	Draft notice to include appeal rights, information on the continuation of benefits, and how to request an expedited appeal
	Develop policies and procedures for processing requests
	Design notice inserts that describe the various reasons for the denial or reduction in services (e.g., not medically necessary, not a covered service, etc)
Acknowledgement of Appeal	
Grievances and appeals must be acknowledged in writing (typical standard is within five business days).	Develop notices
	Develop policies and procedures for ensuring notices are sent timely
	Develop process and assign staff to assist enrollees in filing grievances and appeals
	Assign staff to receive, date stamp and log in all grievances and appeals

AREA/ DESCRIPTION	TASKS
Resolution of Grievances and Appeals	
OVHA must have a formal process for resolving all grievances and appeals. Providers must be permitted to file grievances or appeals on behalf of their patients if so requested. The following definitions apply: ***An Action means –*** *1) The denial or limited authorization of a requested service, including the type or level of services; 2) The reduction, suspension or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner (as defined by the state); 5) The failure of the public MCO to act within prescribed timeframes.* ***An Appeal means –*** *Any request for a review of an action.* ***A Grievance is –*** *An expression of dissatisfaction with any matter other than an action (e.g., quality of care) [438.400(b)]. Resolution Timeframes: Standard Grievance – 45 days from date of receipt ([438.408(b)(1)] =90days); Standard Appeal – 45 days from date of receipt [438.408(b)(2)]; Expedited Appeal – Three (3) business days from date of receipt [438.408(b)(3)]*	Develop policies and procedures for the receipt, acknowledgement and resolution of grievances and appeals
	Develop a system for logging and tracking grievances and appeals (type, days to resolution, outcome)
	Develop a system for automated reporting on grievances and appeals
	Assign staff to process all grievances and appeals
	Design resolution notices
Fair Hearings	
OVHA must ensure that enrollees have the right to request a fair hearing within no less than 20 days or more than 90 days from the date of the notice of resolution of the grievance or appeal. [438.408(f)]. AHS, as the oversight entity, must ensure that the fair hearing is conducted in accordance with all applicable state and federal regulations including timeframes for the conduct of the hearing and the enrollee's due process rights.	Develop policies and procedures for coordinating between the Grievance and Appeals process and the state Fair Hearing process
	Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing
	Develop reporting system to track number, types, timeliness and resolution of fair hearings

AREA/ DESCRIPTION	TASKS
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)	
QAPI Plan	
OVHA must develop a strategy and plan which incorporates procedures that: 1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees, including those with special health care needs [438.204(b)(1)]; 2) Identify the race, ethnicity and primary language spoken by each Demonstration enrollee [438.204(b)(2)]; 3) Provide for an annual, external independent review of the quality outcomes and timeliness of, and access to, the covered services under the Demonstration [438.204(d)]	Draft initial plan and strategy
	Submit final draft to CMS for review
Source of Primary Care	
VHAP must ensure that each Demonstration enrollee has an ongoing source of primary care. [438.208(b)(1)] It must further implement mechanisms to identify persons with special health care needs. [438.208(b)(4)(c)] The quality strategy must specify these mechanisms. [438.208(b)(4)(c)(i)]	Develop policies and procedures for the selection of a PCP by each Demonstration enrollee
	Design information system capacity to capture the PCP information for each enrollee
	Develop a mechanism for tracking PCP caseload
Practice Guidelines	
VHAP must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and which are adopted in consultation with contracting health care professionals. [438.236(b)]	Establish a medical advisory task force of contracting professionals to provide consultation on the guidelines to be
	Select key areas where guidelines are to be developed
	Research evidence-based guidelines and protocols for each of the key areas
	Adopt the appropriate guidelines after consultation with the task force
	Distribute guidelines to appropriate network providers

AREA/ DESCRIPTION	TASKS
Measuring Performance Improvement	
VHAP must operate its QAPI program on an ongoing basis and conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Procedures must be in place to collect and use performance measurement data and to detect both under- and over-utilization of services. Mechanisms must also be in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs. [438.240(a), (b), (c), & (d)]	Establish QAPI oversight committee
	Identify key performance indicators
	Develop baseline data on current status of selected indicators
	Establish improvement goals
	Collect and analyze performance data annually
	Develop audit tools and processes for the biannual clinical care audits and program reviews
	Develop report formats
	Prepare annual performance report for CMS
	Develop process and procedures for incorporating grievance and appeals information into the QAPI plan
	Develop and maintain database for monitoring quality indicators
	Develop process and policies for the establishment of annual QI goals
	Develop Member Satisfaction Survey guide and submit to CMS for approval
PROGRAM INTEGRITY	
Actuarial Certification of Capitation Rates	
VHAP must provide CMS with an actuarial certification of the capitation rates that will be used as the basis of payment of Medicaid funds to the health plan. The rates must be certified by an actuary who meets the standards established by the American Academy of Actuaries. [438.6(c)(4)(i)]	Develop database for actuaries
	Establish capitation rates by MEG
	Obtain written certification from qualified actuary
	Submit rates to CMS
	Develop process for periodic recertification of rates
Compliance Plan	
VHAP must also have administrative and management arrangements and/or procedures, including a mandatory compliance plan, that is designed to guard against fraud and abuse. This includes written policies, procedures and standards of conduct. A compliance officer must be designated and a compliance committee formed that is accountable to senior management. An effective training and education program must be developed and implemented for the compliance officer and other VHAP employees. [438.608(a) &(b)]	Appoint compliance officer
	Develop written compliance plan
	Develop policies and procedures for program integrity
	Develop written standards of conduct
	Design staff training program
	Conduct staff training

AREA/ DESCRIPTION	TASKS
MONITORING	
Utilization	
OVHA must monitor the program to identify potential areas of over- and under-utilization. Where such over- or under-utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]	Develop an overall utilization management plan for the Demonstration
	Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc)
	Develop process and plan for periodic measurement using claims data
	Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG
Provider and Enrollee Characteristics	
OVHA's health information system must track certain characteristics of its network providers and enrollees (e.g., enrollees with special health care needs; providers with accom-modations for the disabled in their offices) [438.242]	Develop system design for capturing selected characteristics
	Develop a provider profiling plan that monitors and reports on enrollment, encounters, reimbursement and outcomes on a monthly basis
	Execute plan for incorporating additional fields within the MMIS
	Develop report formats
Enrollee Rights	
Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.	Draft policies and procedures
	Develop staff training plan
	Disseminate policies and conduct staff training as needed
Encounter Data Validation	
OVHA must put in place a process for validating encounter data and for reporting information on encounters/ claims by category of service. [438.242]	Develop validation process
	Establish schedule for encounter data validation activities
	Develop validation report format

AREA/ DESCRIPTION	TASKS
ENROLLEE ACCESS & PROVIDER NETWORK	
Availability of Services	
OVHA must ensure that an adequate network of providers to provide access to all covered services is under contract to the state. This includes an assessment of geographic location of providers, considering distance and travel time, the means of transportation ordinarily used by Medicaid enrollees and whether the location provides for physical access for enrollees with disabilities. The assessment must also consider the number of network providers who are NOT accepting new Medicaid patients. OVHA must also ensure that network providers offer hours of operation that are no less than those offered to other patients. OVHA must also subcontract with other selected AHS departments that will provide services to Demonstration enrollees. [438.206]	Conduct geo-access analysis of current network
	Identify any existing gaps
	Recruit additional providers as needed
	Develop process and procedures for provider site visits if warranted
	Develop ongoing monitoring plan for the provider network
	Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled
	Develop contracts (IGAs) with other departments
	Establish policies and procedures to ensure compliance by subcapitated entities
	Develop a monitoring plan for oversight of these entities
CMS REPORTING	
General Financial Requirements	
AHS/OVHA shall comply with all general financial requirements under Title XIX. AHS must maintain financial records, including the following: 1) Monthly comparisons of projected vs actual expenditures; 2) Monthly report of OVHA revenues and expenses for Demonstration program; 3) Monthly comparisons of projected vs actual caseload, 4) Quarterly analysis of expenditures by service type; 5) Monthly financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]	Document any modifications to current report formats that will be required
	Assign staff responsible for the production and submission of the required reports
Budget Neutrality Reporting	
For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the state shall provide to CMS a report identifying actual expenditures under the Demonstration. [STC pg. 20]	Obtain report format from CMS
	Make any necessary changes to reporting processes and procedures to accommodate the CMS-specified report formats
	Assign staff responsible for the production of the reports
	Develop policies and procedures for the development of corrective action plans if actual expenditures exceed the levels permissible under the Demonstration STCs (by year)